Issues in Employment and Insurance

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There is a distinction between health insurance and health care. To hear the national debate over the last few years, that might not have been entirely clear.

Certainly, health insurance, the availability of it or the lack of it, affects health outcomes, and, therefore, health insurance, the extent to which it is available or not available, is a very major concern and should concern us all.

The nation had an election in November 1994. Our organization was in the field on election day and the next day nationwide, trying to find out what the public's views were on health issues. The part that surprised us and was very gratifying was that the public indicated that they would be disappointed if the new Congress did not act on health reform. The public also indicated, much to the surprise of many of us, that health care issues were equal with crime and drugs as major factors that influenced how they voted on November 8.

That, however, does not mean that there is a clear mandate about what the public really wants to happen. The public appears to be gun-shy about comprehensive reform and less than enthusiastic about a growing role for government in dealing with health issues, or much else for that matter. The public sometimes seems to want national health insurance as long as the government has nothing to do with it and universal coverage so long as somebody else pays for it.

I think one of the key frustrations of those of us who have been

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involved in this field over the years, is that the public debate of the last couple of years has not accomplished much in increasing public understanding of the trade-offs. It is a keen disappointment to realize how many people are convinced that if you could squeeze out waste, fraud, and abuse we could pay for a generous package of health benefits for every American. That is not true, but it is an easy way out of confronting the real choices that have to be made.

As the elections showed, and as our own surveys have indicated, the sensitivity of these issues is especially pronounced in the South and the border areas of this country. While there certainly were other changes that affected the election outcome, it was particularly pronounced there.

In a sense, an event even more significant than the congressional elections with regard to public attitudes on this subject was the vote that took place in California on November 8. Over 20% of California's population is without health insurance today. The latest estimate of the number of health-uninsured in our nation's largest state is 6 1/2 million. A single-payer proposition was turned down on November 8 by approximately three to one.

One can conclude whatever they might from that, but it does suggest that the attitudes with regard to a governmental role that I alluded to earlier are not confined to just one part of the country.

Before President Clinton even took office, the Health Insurance Association of America came out in favor of universal coverage. We have advocated an employer-employee mandate to pay for it as a means of financing. We felt that there should be a federally defined benefit package. None of this happened.

To make it absolutely clear what our views were, we objected, very strongly, to two points in the President's program. We objected to the notion that virtually every American be required by law to purchase their health insurance through a to-be-created state agency called a health alliance or a health insurance purchasing co-op, and we objected to the notion that premium limits should be established throughout the country.

But having said that, quite apart from what our views may have

been or are today, I think it is clear that, at least in the short run, there are certain things that are simply off the table even though many of us wish they were on the table. Universal coverage is off the table. Mandates on employers or employees or individuals who can afford to do so, to buy health insurance, are off the table. A federally defined benefit package is off the table. Probably most pertinent with regard to care for children, the necessary subsidies to help uninsured people afford coverage (because the main reason people do not have health insurance is, they cannot afford it) are not on the table either, because anything that looks like a tax is not particularly popular right now among the people that have been entrusted for a couple of years with making laws for the country.

I think that the significance of this is that the basic problems we have seen in the last few years are likely to get worse rather than better. Two of these problems deserve special attention. One problem is the likely increase in the number of health uninsured, a number that has been moving upwards in a very steady and disappointing manner. Estimates vary, but it is certainly well over 40 million. The other problem, which is significant and does not receive as much attention as the first, is the decline in the proportion of the population covered by employer-paid health insurance. The conventional wisdom is that this is a result of the shift of jobs into service businesses and smaller enterprises, places with smaller groups of employees. Allthough it is true that service businesses and smaller work forces tend to coincide with less health insurance, some recent studies question that conclusion. There is some evidence that health insurance is so expensive that there is a movement away from providing it on the job, quite apart from the size of the employee work force or the economic function of the business itself.

If all this is true, then the real health care revolution is occurring in the market and is unlikely to occur any time soon through federal or state legislation.

We should keep two things in mind about revolutions. The first

is that revolutions breed counter-revolutions, and the second is that the outcome of a revolution cannot always be foretold.

Regarding the first point, the counter-revolution, we are seeing this now in efforts, primarily at the state level, to slow down the rate of change in health care delivery and in health care financing, through legislative actions; in other words, to stop the markets from moving in their current directions. This is shown, particularly, by efforts to pass any so-called willing-provider laws and patient-protection laws at the state level. Basically these are anti-managed-care initiatives, and the medical profession in many states has taken the lead in promoting these ideas. Fundamentally, they are attempts to limit market options by having the legislature define what is and what is not acceptable in the way of contracting for medical services.

One of the interesting political sidelights of this is that, while these plans would, to some degree, increase the costs of health insurance (not exactly what the public wants right now), there is no broad public awareness of that fact. Indeed, among businesses that buy most of the private health insurance in this country, there is little awareness that they even have anything at stake in the arguments about any willing-provider, patient-protection legislation.

I expect that as a result of this counter-revolution, we are going to hear a lot more about choice than about costs, and watch that. I think that's actually beginning to happen. The definition of choice is interesting. We in the insurance business define choice as the importance of purchasers of health insurance having a choice among different health plans, whereas the providers describe it as a choice of physician or hospital or pharmacy or whatever it may be.

Choice is a slippery concept. It is worth defining and working your way through, but it has many meanings to many people.

Another characteristic of a revolution is, you do not know how it will come out. I do not think there is any question that managed care is growing, but managed care has many meanings as well. The great growth is not in closed-panel, staff-model HMOs. It is, at

least at the moment, in the intermediate forms: in the PPOs and in those managed-care arrangements that offer a meaningful out-of-network option.

Indeed, what works in one community may not work in another. One item often neglected in these debates is that most health care is delivered in local markets. There is no national market for health care except in a very few, very rare illnesses and very rare diseases. Therefore, the form of organization for both insuring and delivering health care that works in my home town of Cincinnati may flop in Columbus, a hundred miles away. There is no clear situation where one can say, "Well, look how it's working out in mature markets like San Diego; that's how it's going to work in New York City." Maybe it will, maybe it won't.

One of the regrettable but realistic results of this increased emphasis on trying to hold down health care costs, however, is that it is going to force us to make some societal decisions with regard to some very important components of the health care system, decisions that have been submerged in the past. Specifically, I refer to the financing of medical education and the financing of health care for low-income populations.

We have for some years had add-ons for Medicare, for example, for direct and indirect medical education expenses, and also, of course, the disproportionate share adjustment. Cost shifting, whether through the governmental programs or through the private sector, is getting harder to do. As a result, those institutions that have an interest in maintaining adequate funding for these functions—research, training, care of the poor—are going to have to face these in a more explicit manner. Hidden, implicit subsidies will have to be replaced by very visible, transparent, explicit subsidies if financing is to continue. That will cause a careful examination of some issues that have been left to the profession in the past.

What are the cutting-edge issues that we are going to deal with? I think one of the most interesting, from an organizational point of view in terms of financing and delivery, has to do with public

programs. Currently, in this country, governments—federal, state, and local—pay about 44% of all health care bills.

The big, flagship programs, specifically Medicare and Medicaid, are in a sense single-payer programs for defined populations; single payer in the sense that the federal government, in the case of Medicare, and the state governments, in the instance of Medicaid, define the population and define how much they will pay for each procedure, how much for a day in the hospital, and so forth.

I think it will be quite interesting to see whether that method of financing holds up in the current environment. It would not surprise me if there was a movement in these programs over time to buy health insurance for those populations in something closer to the way the rest of the population buys health insurance. Government might well (and, I certainly expect, will) continue to pay for these populations, but perhaps instead of being the insurer itself it might buy through the health plans that the rest of the population looks to in their individual areas. It is something to watch.

One could envision, for example, in Medicare, in addition to the current fee-for-service and HMO or CMP options, the so-called risk contracting, the addition of point-of-service plans, PPO plans, medical savings plans, and possibly some arrangement under Medicare where an employee, on reaching 65 or whatever the eligibility age is in the future, could stay under the employer's plan. Coverage would be seamless but the payment would come from Medicare to reimburse the employer in some appropriate manner.

There are many initials and acronyms out there. I have learned of a new one: OWAs, which means "other weird arrangements." I think that as this field develops, we will see a lot of OWAs. I do not think we have seen the end of the variations which will arise as managed care progresses. And managed care, in my definition, simply is a merging of the insurance function with the delivery function; the rest is just definition and variations on that theme.

I also should mention, in terms of issues that do not get much attention, the matter of ERISA. The bulk of employees in this

country is not covered by insured arrangements, but rather by self-funded plans made available by the employers. In 1974, Congress made it possible for multistate employers to set up plans so they did not have to meet 50 different standards if they operated a business that cut across state lines. But participation in these plans is not limited to multistate employers.

In a sense, ERISA is the ultimate deregulation. If you want to avoid state mandates, if you want to avoid state premium taxes, if you want to avoid state reforms, you can set up a self-funded plan. That is a dynamic I would encourage all who are interested in the insurance issue to consider, because there is an uneasy balance, and the notion that it is possible to regulate insurance to get it to do anything you want to, really does not work out in practice.

In fact, it was interesting to note, over the last couple of years, how often the First Family, with whom we didn't agree on some things, cited the experience of the State of New York to indicate how not to reform health insurance markets and cited the open enrollment community rating requirements in this state as evidence of how, done poorly, reform can come to mean fewer people insured and at higher rates, by causing younger, healthier people to drop out of the pool entirely.

One has to deal with these things very, very carefully.

Portability is something that we think can be achieved only in part in a nonuniversal setting. Over the next few months, I think we will see more and more evidence of how hard it is to achieve our goals: broader coverage and at reasonable rates in a nonuniversal setting. It is easy to say we want portability as people move from plan A, where they worked, to plan B if they change jobs. You can say to plan B that they cannot impose a new pre-existing condition requirement and so for this you met the standard under plan A. But that is the easy, simple case. The harder case is, what happens if you go from employer A, who has insurance, to employer B, who does not, or from employer A, who has health insurance, into the individual health insurance market? If you think the answer is just to require people who sell individual policies to guarantee issue at standard rates, it will cause an

explosive increase in the cost of insurance, because of the self-selection. Sicker people tend to buy the insurance; there is a wealth of experience under COBRA and conversion policies to bear this out.

So we think there is opportunity for insurance reforms, but that it is useful not to over-expect what they can accomplish.

I close by sharing with you what I think is happening in our industry, which is a means through which society attempts to get people covered. The changes are so dramatic that my point of view might be useful; it might help in our joint thinking about what is happening.

I thought the two most important things that happened in health care and health insurance in 1994 were the following: (1) the decision of the Blue Cross organizations to permit for-profit operation, and (2) Prudential withdrawing from the Twin Cities' markets. In terms of what is going on in the industry today, those events may make more sense than they might otherwise.

An enormous consolidation is taking place in health insurance in this country, and it is not just a dropping out of the hundreds of small companies that never did that much in the business anyway. About 200 health insurers write 94% of all the health insurance in this country; a substantial degree of consolidation already exists. But think about who has exited in the last few years—Metropolitan, Travelers, Equitable, Hartford, Lincoln National. This is not a high-profit business; the profits average less than 2% over time, and a lot of companies are getting out of the business.

What we seem to see is an increasing amount of business being written by enterprises that specialize in health insurance. We are accustomed to that from the Blue Cross organizations, but the commercial, multiline carriers are tending to split off their health care business or sell it off or get out. They walk away from it if it is not profitable.

A couple of years ago, when I came into this job, I found that two-thirds of all health insurance in this country was written by enterprises that were not shareholder-owned; that is, they were either not-for-profit or mutual. That is changing, and the great

movement is toward for-profit, shareholder-owned operations, mainly because of the extraordinary amounts of capital required to provide managed care, and the fact that in the mutual form it takes so long to retain enough profits to be able to do the things that need to be done in a managed-care context.

Integration of the insurance and delivery functions is working both ways. Insurers are getting into delivery, and hospitals and physicians are getting into the insurance business. They will probably meet somewhere, but that is where we are getting the physician-hospital organizations and other varieties that some of us hadn't even heard of until recently.

Finally, we seem to be moving away from a fee-for-service system towards a managed-care system. From the point of view of health care delivery and ethical issues, neither one of these is perfect.

Fee for service tends to over-utilization, over-testing, and unnecessary medical procedures, and there is powerful evidence to back up that generalization. Managed care, of course, runs the risk of under-utilization. Lacking the kind of comparative data that someday we will have, it is extremely difficult to make intelligent judgments about one managed-care plan versus another, or, for that matter, managed care versus fee-for-service, from a qualitative point of view.

Neither of these is a magic bullet. Over time, however, as a result more of workings in the marketplace than through legislation, we should get a clearer idea of how it will all work out.